PREA AUDIT REPORT ☐ INTERIM ☑ FINAL
JUVENILE FACILITIES

Date of report: 06-27-16

Auditor Information			
Auditor name: Candy Snyder			
Address: PO Box 405, Custer SD 57730			
Email: Snyder@gwtc.net			
Telephone number: (605) 517-1747			
Date of facility visit: December 16 - 17, 2015			
Facility Information			
Facility Name: Ocean County Juvenile Detention			
Facility physical address: 165 Sunset Avenue, Toms River New Jersey 08754			
Facility mailing address: *(If different from above)*			
Facility telephone number: (732) 288-7708			
The facility is:	☐ Federal	☐ State	☑ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility Type:	☐ Correctional	☑ Detention	☐ Other
Name of facility's Chief Executive Officer: Walter Hopson			
Number of staff assigned to the facility in the last 12 months: 51			
Designed facility capacity: 47			
Current population of facility: 13			
Facility security levels/inmate custody levels: minimum/Normal, Special Schedule, Security Watch			
Age range of the population: 14 to 19			
Name of PREA Compliance Manager: Robert Knight			
Email address: rknight@co.ocena.nj.us			
Agency Information			
Name of agency: Ocean County			
Governing authority or parent agency: *(if applicable)*			
Physical address: 101 Hooper Ave. Toms River, NJ 08754			
Mailing address:*(if different from above)* P.O. Box 2191 08754-2191			
Telephone Number: (732) 244-2121			
Agency Chief Executive Officer			
Name:		**Title:**	
Email address:		**Telephone number:**	
Agency-Wide PREA Coordinator			
Name: N/A (Robert Knight)		**Title:**	
Email address:		**Telephone number:**	

AUDIT FINDINGS

NARRATIVE:

An audit of the Ocean County Juvenile Detention Center (OCJDC) facility in Toms River, New Jersey was conducted on December 16-17, 2015 by Candy Snyder, a certified PREA auditor, and assisted by Mark Snyder, an auditing assistant.

An entrance meeting began with facility staff Dr. Barbara Barr, Asst. Superintendent, Bob Knight, PREA Coordinator, and Alex Ivanov, Chief of Custody. The Superintendent, Walter Hopson, was out of state.

Dr. Barr, Bob Knight and Chief Ivanov accompanied the audit team on the facility tour. The auditor then began interviewing specialized staff. Suitable and private accommodations were made for the auditor to conduct interviews. The auditor was not limited in any way from speaking with staff or youth or inspecting any area of the facility. The auditor was given access to the facility at all hours of the day in order to conduct interviews with staff on all shifts. All staff were extremely polite and accommodating throughout the audit. OCJDC is a rather small facility and key staff hold multiple positions.

The auditor conducted a review of the application and hiring process and employee background checks. The auditor reviewed all investigative files. There was one sexual assault allegation case reported within the past year. At the time of the on-site portion of the audit it was under investigation by the Department of Children & Families Institutional Abuse Investigation Unit and the Ocean County Prosecutors' office. Investigative files were reviewed and investigations were handled appropriately and per the standards.

Chief Ivanov provided a copy of the staff schedule. The auditor randomly selected ten (10) staff and conducted interviews of staff covering all shifts, varying degrees of longevity, diverse job classifications and staff who worked within varying areas of the facility. The auditor asked specialized questions of those line staff that perform screenings, perform searches, who are first responders, and staff who conduct the intake process.

The auditor completed interviews of ten (10) youth with varying lengths of stay and youth from both housing areas. There were no residents who were disabled or who were limited English speaking to be in interviewed. A youth identifying as gender non-conforming was interviewed. At the time of the on-site portion of the audit the facility did not have a screening process and therefore there were no youth who were screened and had identified previous sexual abuse prior to placement. During the corrective action period a screening process was implemented. The facility states that it does not use isolation for protective custody and this was confirmed through direct observation and through interviews.

An exit briefing was held with the PREA Coordinator, the Chief of Custody, the Social Worker Supervisor and the nursing staff. The auditor provided a preliminary finding of each standard with the caveat that this was subject to change as the auditor continued to review documents, may have questions to be answered and prepares the interim report. The auditor thanked the OCJDC staff for their hard work, their hard work yet to come, their commitment to follow the Prison Rape Elimination Act and most importantly, their dedication to and caring for the youth under their charge.

Over the next six months the auditor and the OCJDC staff worked through the correction action period to meet each standard.

DESCRIPTION OF FACILITY CHARACTERISTICS:

The Ocean County Juvenile Detention facility is located in Toms River in Ocean County, New Jersey. The facility is a relatively new building that is very well taken care of with adequate room for juvenile services. The facility is comprised of one building and a secure, fenced-in outdoor recreation area. The building consists of administrative areas, intake area, dining room, kitchen, education area with classrooms and offices, and three housing pods– two for male youth and one for female youth and younger male youth. Each pod contains an open dayroom area, a staff office, and eight (8) single sleeping rooms. There are two shower rooms and restrooms within each pod. Youth shower and toilet privately in single bathrooms. There is a gymnasium for indoor recreation, a center courtyard for basketball and an exterior recreation area. Throughout the tour of the facility the auditor noted PREA posters and the required posted Audit Notice.

SUMMARY OF AUDIT FINDINGS:

The facility has been working on implementation of PREA compliance measures over the past year for the Ocean County Juvenile Detention. The facility has very thorough policy on PREA (Chapter 16.1) and PREA related procedures. Although not all standards were fully met at the time of the on-site portion of the audit, Staff and youth were aware of PREA and staff were committed to youth safety. Most importantly when asked, all youth stated that they felt safe at OCJDC. Staff worked diligently throughout the corrective action period to implement all requirements identified by the auditor.

Number of standards exceeded:	**0**
Number of standards met:	**39**
Number of standards not met:	**0**
Number of standards not applicable:	**2**

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

OCJDC has a very thorough PREA policy (Chapter 16.1) and many other policies related to PREA protective measures and reporting. They appointed a PREA Coordinator who has been working tirelessly to address every standard. The PREA Coordinator has the authority to develop, implement and oversee the efforts of the facility to prevent, detect, and respond to sexual abuse and sexual harassment. He has the complete backing of the OCJDC administration.

Standard 115.312 Contracting with other entities for confinement of residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard is not applicable. The facility does not contract for the confinement of its residents with other private agencies/entities. However, as the facility has an informal "courtesy hold" process with Burlington County Juvenile Detention Center, the auditor recommended that they complete a letter with a statement that is signed by each Superintendent that reads as below. It is important to note that the auditor was also performing audit services for Burlington County Juvenile Detention Center and was aware of their commitment to follow the PREA Standards.

The (receiving) Juvenile Detention Center will comply with the Prison Rape Elimination Act of 2003 (Federal Law 42. U.S.S. 15601 ET. Seq.), and with all applicable PREA Standards related to PREA for preventing, detecting, monitoring, investigating, and eradicating any form of sexual abuse within your Facilities/Programs/Offices owned operated or contracted. The (receiving) Juvenile Detention Center acknowledges that, in addition to "self-monitoring requirements" the (sending) Juvenile Detention Center may conduct announced or unannounced, compliance monitoring to include "on-site" monitoring. Failure to comply with PREA, including PREA Standards may result in termination of the courtesy hold agreement between the (receiving) Juvenile Detention Center and the (sending) Juvenile Detention Center.

Standard 115.313 Supervision and monitoring

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

At the time of the on-site portion of the audit OCJDC did not have a documented staffing plan or annual review. The annual review must outline the camera surveillance systems, staff coverage, adequacy of supervision and prevailing staffing patterns over the previous year. This process of evaluation of staffing levels must be completed in future years to continue to remain in compliance with this standard. The auditor did note that staffing ratios have been met over the past year.

The facility does have within the PREA Policy 16.1 and Policy 6.4, Section III, E. the requirement for intermediate or higher level managers to conduct and document unannounced rounds. However, the facility interpreted this standard to mean the shift supervisors. The intent behind the standard is that administrative managers who normally are not assigned in the general work area where youth are present, complete rounds within youth housing areas that are unannounced (and unexpected) as a means of deterring sexual abuse and sexual harassment. The Chief of Custody does stop in from time to time after hours, but this specific visit had not documented in an unannounced rounds logbook.

CORRECTIVE ACTION: The auditor required the OCJDC administrators to complete a documented, annual review. This review must assess staffing to ensure continued adequate staffing levels and determining the need for video monitoring. The staffing plan must take into consideration the 11 items noted in this standard. On June 10, 2016 the annual review was provided to the auditor.

The auditor required the facility to implement the practice of intermediate-level or higher level supervisors conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment. The auditor required the practice be implemented for night shifts as well as day shifts. The auditor recommended that these rounds be conducted by the Chief of Custody, the Assistant Superintendent and the Superintendent. On April 15, the facility provided documented evidence that these unannounced rounds were being conducted by upper level staff and that the practice was consistent since its inception in January.

Standard 115.315 Limits to cross gender viewing and searches

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility does not conduct cross-gender strip searches, cross-gender pat-down searches or cross-gender visual body cavity searches. This was verified through interviews with both staff and youth. The facility did not have an exigent circumstance log in the event of an emergency in which to document a cross-gender search. An emergency event could arise in which a male would have to perform a search of a female youth during an exigent circumstance. The facility prohibits cross-gender searches, but still must provide cross-gender search training in the event an exigent circumstance occurs. In addition, there was no documented training of how to properly conduct a search of a transgender or intersex resident.

The facility has good policies and procedures in place that enable residents to shower, toilet and change clothing without staff of the opposite gender viewing them naked. Staff announce their presence when entering a housing area of youth of the opposing gender. These procedures were confirmed through staff and youth interviews and direct observation by the auditor. There have been no instances of transgendered or intersex residents admitted to the facility. However, OCJDC staff were aware of the responsibility of determining sex solely through professional conversation or through medial records or through part of a broader medical examination by a medical practitioner.

All youth sleeping rooms have windows to the outside to allow for natural daylight. However, this also allows for the inadvertent viewing of a resident if staff are conducting exterior grounds security rounds outside of the resident's room. The auditor recommended that some type of opaque spray or film be applied to windows to prevent inadvertent viewing of residents that may be in a state of undress.

CORRECTIVE ACTION: The auditor required that the facility provide all staff with cross-gender search training, when to conduct such searches and to document these searches on an exigent log if they take place. On April 4, 2016 the facility staff provided training records to the auditor on cross-gender search training. On April 15, the facility staff provided the exigent circumstance log.

The auditor required the OCJDC staff provide photographic evidence that an opaque material be applied to the windows to avoid viewing residents within their room from those who are outside in the break area or exercise area. These photos were provided on March 10, 2016 and verified that inadvertent viewing of a youth in their room could not take place.

Standard 115.316 Residents with disabilities and residents who are limited English proficient.

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard requires that the facility administrator think ahead of how to effectively handle situations involving a youth who is limited English proficient or may have disabilities so that they may fully participate in protection efforts. They typically do not encounter this, but have identified staff members who are bilingual in both English and Spanish to assist. It is likely that the resident who does not speak English would predominantly be Spanish-speaking in this area. However, this cannot be assured. There have been no instances during this reporting period where resident interpreters, readers or other types of resident assistants were needed or used. The facility does not use residents to interpret for other residents.

CORRECTIVE ACTION: The auditor required the facility have an interpretive service available 24-7 that can assist in the intake process, screening process, education on how to report and if need be, translate during the investigative process. On May 23, 2016 the facility staff provided verification that they had the CTS Language Link in place. Information regarding this new procedure was provided to all staff and the contact numbers are posted in easily accessible areas for staff as verified by photographic evidence provided to the auditor.

Standard 115.317 Hiring and promotion decisions

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility has performed background checks at the time of employment of new hires. The auditor randomly reviewed personnel files and found a couple of employees that did not have background checks within their personnel file. They were not conducting Child Abuse Record Information (CARI) checks at the time of employment. They also did not have a procedure in place for running the background check again every five years or upon promotion. They did not include the required three questions at the end of their application nor require new hires to affirm that they have a continuing duty to report.

CORRECTIVE ACTION: The auditor required that the OCJDC staff run a criminal background check and a CARI check for all existing employees. CARI checks were required for all employees that were hired since August 20,

2013. The facility staff were also required to develop a process for ensuring that the criminal background check is completed again every five years or if an employee is promoted into a new position. The auditor required the three questions regarding sexual misconduct be added to their application as well as a statement that they have a continuing duty to report

On April 29, 2016 the auditor received the updated application that included the three sexual misconduct questions asked of applicants and the signed statement acknowledging that if the applicant is employed that they understand that they have a continuing duty to report any sexual misconduct. On June 21, 2016 the auditor received documentation to confirm that all background checks, CARI checks and pre-employment screening were complete for all employees. In addition, the OCJDC Superintendent satisfactorily outlined the processes implemented to ensure that five year re-checks and re-checks upon promotion would be a matter of continued procedure for the facility.

Standard 115.318 Upgrades to facilities and technology

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There have been no major expansions or modifications at this facility. The administrators consider the ways in which to enhance their efforts and abilities to protect residents from sexual abuse through the use of electronic monitoring and video monitoring. They have camera systems in all key areas. Additionally, they have electronic monitoring in which they can hear (but not record) the conversations within rooms from the control room. They recently made a request and have been approved for additional funding to improve their camera systems. The have 55 cameras that were installed in 1991. They recently learned that their digital recordings were dumping stored video footage before the required 30 days of holding. The additional funding will be used to upgrade cameras and rectify the video storage issue.

Standard 115.321 Evidence protocol and forensic medical examinations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

As soon as the administrator is notified of a sexual abuse the protocol is to call both the Division of Child Protection and Permanency (DCP&P) and the Ocean County Prosecutor's Office. The Ocean County Prosecutor's Office – Special Victims' Unit specializes in the investigation and prosecution of cases involving the sexual abuse of children. The unit is staffed with two Assistant Prosecutors, a Lieutenant, a Senior Ranking Detective as well as five additional Detectives, a Victim-Witness Advocate and the coordinator of the Sexual Assault Nurse Examiner (S.A.N.E.) program. The members of the Special Victims' Unit are specially trained to conduct and/or assist local law enforcement agencies with sexual assault investigations including but not limited to the crimes of Aggravated Sexual Assault, Sexual Assault, Aggravated Criminal Sexual Contact, Criminal Sexual Contact and Endangering the Welfare of Children. Additionally, cases in this unit are prosecuted with the same Prosecutor and Detective from investigation through trial and sentencing so as to minimize the trauma to the victims and their families.

The OCJDC staff are implementing a Memorandum of Understanding (MOU) with a local advocate from a rape crisis center. St. Francis is the local advocacy agency in Ocean County. St. Francis has trained advocates that provide

counseling to survivors of sexual assault. They also provide accompaniments to hospitals, police stations and courts. In addition, the Supervising Social Worker at the OCJDC has completed the St. Francis training workshops and has been certified as a Rape Advocate and does volunteer work at the St. Francis Community Center.

CORRECTIVE ACTION: The OCJDC and St. Francis have been working well together over the past year on the agencies support services for youth. The auditor required that OCJDC set up a formal MOU with St. Francis for these services. The MOU has been completed and is on the docket for adoption by the County Freeholders in June. On June 22, 2016 the auditor spoke with staff from St. Francis and verified that they will provide an advocate to accompany a victim of sexual assault to the hospital and throughout the investigative process; they will accept phone calls from youth housed at the OCJDC for counseling services and they will provide face-to-face counseling if the OCJDC staff transport youth to the St. Francis facility. All OCJDC staff have been trained in these coordinated response efforts.

Standard 115.322 Policies to ensure referrals of allegations for investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The procedures are in place to always notify the prosecutor's office and DCP&P for every incident of sexual abuse. There is written policy (PREA Policy 16.1) that states all allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. This investigative policy was not published on the OCJDC website.

CORRECTIVE ACTION: The auditor required the investigative policy be posted on the OCJDC website. This was completed on March 21, 2016 and verified by the auditor.

Standard 115.331 Employee training

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The OCJDC provides PREA training to all staff. However, the facility only had a roster with signatures title "PREA Training". They must document, through employee signature, that employees understand the training they have received and list the components of the training. During the interviews staff were able to satisfactorily relay to the auditor all points as outlined in the standard.

CORRECTIVE ACTION: The auditor required that the signature sheet used by the facility to track training outline specifically what was taught and staff must attest that they understand the training that they have received through their signature. On April 4, 2016 the facility trainer provide signature sheets in which the staff attested to understanding the 11 items outlined within this standard.

Standard 115.332 Volunteer and contractor training

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The OCJDC provides PREA training to volunteers and contractors at a level that is dependent upon their level of contact with the youth. For example, teachers have more training than the food service worker and this was verified through interviews. A contracted food service worker was interviewed and stated that the facility has a zero tolerance policy and that they are required to report any knowledge, suspicion or information regarding sexual abuse or sexual harassment. Youth are never allowed in the kitchen and the food service worker serves food through the serving window between the kitchen and dining room. There is no direct contact between a food service worker and youth.

CORRECTIVE ACTION: The auditor required that the signature sheet used by the facility to track training outline specifically what was taught to volunteers and contractors and that they attest that they understand the training that they have received through their signature. On June 1, 2016 the facility trainer provided signature sheets in which the volunteers and contractors attested to understanding of the training.

Standard 115. 333 Resident education

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility provides residents information on the OCJDC zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. This was evident through the interviews with youth. They stated that they received some basic information immediately (during intake) and then later typically with 1 to 2 days they would meet with a Youth Services counselor who would give them more comprehensive education. The youth also spoke to the information being readily available through the handbook and with posters everywhere throughout the facility.

CORRECTIVE ACTION: The auditor required the facility staff outline specifically what was taught and that residents attest that they understand the training that they have received through their signature. This documentation is required for both the initial, basic training to residents done upon intake and the more thorough comprehensive training completed by the Social Worker within the first ten days. On April 15, 2016 the facility staff provided the auditor signature sheets in which residents acknowledges receiving both training sessions.

Standard 115.334 Specialized training: Investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The OCJDC staff do not conduct sexual abuse investigations. The Ocean County Prosecutor's office and the Department of Children & Families Institutional Abuse Investigation Unit investigators conduct sexual abuse investigations. Investigators from these units have received specialized training in conducting such investigations in confinement settings. Three of the facility staff have completed the NIC course *PREA: Investigating Sexual Abuse in a Confinement Setting* to better able them to assist with administrative investigations of sexual harassment.

Standard 115.335 Specialized training: Medical and mental health care

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Through interviews with the nursing staff it is apparent they are knowledgeable in how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to victims of sexual abuse and sexual harassment; and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment. However, the facility was not able to provide documentation that medical and mental health practitioners received the specialized training.

Corrective Action: The auditor required documented evidence that medical and mental health practitioners received the specialized training as outlined in the standard. On June 1, 2016 the facility trainer provided certificates from the NIC on the course titled *PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting* and the course titled *PREA: Medical Health Care for Sexual Assault Victims in a Confinement Setting* for medical and mental health workers.

Standard 115.341 Screening for risk of victimization and abusiveness

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The OJCDC had identified a screening tool, but had not implemented their screening process. The auditor reviewed the screening tool that they plan on implementing and their process for implementation.
The standard requires that usually within 24 hours but no later than 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the facility maintains and uses information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident. Although the screening asks the evaluator to note if the youth presents a gender nonconforming appearance/behavior, the screener does not ask the youth if they identify as lesbian, gay, straight, bisexual or transgendered. Typically, youth have no issues answering this screening question when asked directly and professionally. It is important to state something to the effect of "I am required to ask this question of all youth, and you do not have to answer the question, but know that the information is protected from disclosure to others. Do you identify as lesbian, bisexual or straight?" or for boys, "Do you identify as gay, bisexual or straight?" or rather ask "if they wish to identify his or her sexual orientation or gender identity. It is important to ensure that the screeners receive training on how to give the screening so that they are sensitive to how they complete the screening professionally and that they have a complete understanding of what the screening is used for.

Corrective Action: The auditor required the facility provide documented evidence of screenings performed on all youth. On April 16, 2016 the facility staff provided screenings and verified that all youth had been properly screened as per the standard. The auditor recommended changing the screening tool. Instead of the screening looking for gender non-conforming appearance or behavior that the screener asks youth "Do you identify as gay, lesbian, straight, bisexual or transgendered?" or "Do you wish to identify your sexual orientation or gender identity?" The facility chose to not follow that recommendation.

Standard 115.342 Use of screening information

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The OCJDC is doing a good job with placements based on all information obtained to make housing, bed, program, and education for residents with the goal of keeping all residents safe and free from sexual abuse. However, they were not using a screening tool and residents had not been formally screened utilizing the screening instrument. The social services counselors meet with the youth either the day of arrival or within 72 hours of arrival. They already had a process for asking questions such as a history of previous sexual abuse and the comfort level of the youth at the facility. They used this information to ensure that the youth is properly housed. This was very evident during the youth interviews.

The facility takes into account transgender or intersex resident's own views with respect to his or her own safety. Those views would be given serious consideration and this was demonstrated through the interviews of youth and staff as well as through direct observation. All youth shower separately at the facility. The facility does not place lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed or other assignments solely on the basis of such identification or status, nor does the facility consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. The facility indicates through interviews that they will consider on a case-by-case basis assignment to a living unit. They consider if the placement would ensure the resident's health and safety, and whether the placement would present management or security problems. Facility procedure is to manage a resident's room placement rather than using isolation as a means for protecting the resident's safety.

Corrective Action: The auditor required all residents be formally screened and to use this information in aiding in housing decisions. On April 16, 2016 the facility verified that all residents had been formally screened.

Standard 115.351 Resident reporting

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The OCJDC provides multiple internal ways for residents to privately report sexual abuse and sexual harassment, or retaliation. Youth often speak with the social services counselors and have ready access to them. They can write a grievance. Social Services counselors assist them in their calls and they can call whomever they choose. They can speak with the nurse privately at any time by simply making the request. They also can speak with the Superintendent by making the request to any staff. They have multiple times throughout the week to call parents and can speak with their attorneys privately when a request is made. During the on-site portion of the audit the facility had the New Jersey Coalition Against Sexual Assault (NJCASA) 24-hour state hotline number posted throughout the facility. However, this number appears to direct calls to the local rape crisis center St. Francis Community Center. This rape crisis center has not agreed to be a reporting site for the OCJDC. The PREA Coordinator will be working with DCP&P to confirm that they can use the state NJ Abuse reporting line through child protection services.

Almost all youth reported feeling very comfortable reporting directly to their staff or another person within the facility. They all reported there is a grievance process. The staff accepts reports made verbally, in writing, anonymously, and from third parties and promptly documents any verbal reports. The facility provides residents with access to tools necessary to make a written report.

Corrective Action: The auditor required the OCJDC provide access to an outside agency that is willing to accept calls from facility residents. The auditor required that they provide the auditor with photographic evidence that this identified number is posted throughout the facility and provide the auditor with an updated rulebook with this number. On March 4, 2016 the facility provided photographic evidence for external reporting numbers. The posters are both in English and Spanish. The facility provides the Sheriff's Department numbers for reports made during normal business hours and the Sex Crimes Detective Unit number for after hours. In addition, the posters provide the number for DCP&P Institutional Abuse Investigations Unit and the facilities PREA Hotline number. The auditor verified the numbers to ensure the parties would be willing to accept calls from the detention center.

Standard 115.352 Exhaustion of administrative remedies

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Residents may submit a grievance alleging sexual abuse or harassment without submitting it to a staff member that is subject of the allegation. The youth does not have to complete any other prior steps in order to submit a grievance for an allegation of sexual abuse. There is also no time limit on when a youth can submit a grievance regarding an allegation of sexual abuse. Staff and youth interviews confirmed their knowledge of how the grievance process can be used to report sexual abuse and sexual harassment.

Standard 115.353 Resident access to outside confidential support services.

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The OCJDC did not have an MOU with a child advocacy organization. The PREA Coordinator worked throughout the corrective action period to coordinate outside support services for the OCJDC youth. The OCJDC provides youth with reasonable and confidential access to their attorneys and parents. In addition, all youth interviewed reported that they had contact with their families regularly. If the youth is involved with the Department of Children and Families, they may already be assigned a Care Management worker who assists them in accessing services through Care Management Organizations (CMO's) that provide a range of treatment and support services to children.

CORRECTIVE ACTION: The auditor required that the OCJDC provide access to an outside support service agency and provide the auditor with a signed MOU with this agency. The auditor required that they provide the auditor with photographic evidence of posters on how to access this service and an updated handbook that includes contact information for this service.

Standard 115.354 Third-party reporting

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

At the time of the on-site portion of the audit the facility had not identified a method to receive third-party reports of sexual abuse/harassment nor distributed the information publicly on how to report sexual abuse and sexual harassment on behalf of a resident.

Corrective Action: The auditor required the agency post on their website how to report sexual abuse and sexual harassment on behalf of a resident. The auditor recommended including this information in a correspondence or information it supplies to parents and guardians of residents as well as posting this contact information in the visit area. The facility posted on their website on March 21, 2016 the information on how to report sexual abuse and sexual harassment on behalf of a resident. On April 4, 2016 they provided photographic evidence that the information for third party reporters was posted in the lobby and visit area.

Standard 115.361 Staff and agency reporting duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The OCJDC requires all staff to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Apart from reporting to designated supervisors or officials and the designated State agency, staff are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Medical and mental health practitioners are required to report sexual abuse to designated supervisors and officials as well as to the designated State service agencies. Medical staff were not well versed in the requirement to inform the residents at the initiation of services of their duty to report and the limitation of confidentiality.

The facility reports all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators. Upon receiving any allegation of sexual abuse, the OCJDC staff promptly report the allegation to the DCP&P, the prosecutor's office, and to parents or legal guardian.

CORRECTIVE ACTION: The auditor required that notices be posted within the medical offices of the limits of confidentiality when reporting sexual abuse. On March 10, 2016 the OCJDC provided photographic evidence of the posters within the medical office.

Standard 115.362 Agency protection duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Through interviews with the administration and random staff there is evidence to support that the facility requires all staff to take immediate action to protect the resident from imminent sexual abuse. There have been no instances that a resident was subject to risk of imminent sexual abuse.

Standard 115.363 Reporting to other confinement facilities

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Through interviews with administrators and through policy there are procedures in place to appropriately act upon an allegation of sexual abuse reported by a resident while at another facility. This notification will be made from Superintendent to Superintendent, the action will be initiated no later than 72 hours and the action will be documented. There have been no reports by the OCJDC residents of sexual abuse that has occurred at another facility.

Standard 115.364 Staff first responder duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The OCJDC staff seemed to be well versed in first responder procedures and were aware of all elements of this standard (separate alleged victim/abuser, preservation and protection of crime scene, to include collection of physical evidence as soon as possible, including the request of the victim not to take any actions which could destroy any physical evidence). Interviews with random staff confirmed knowledge of these procedures.

Standard 115.365 Coordinated responses

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility has a written policy Chapter 7.6 *Coordinated Response to PREA Incidents* which governs the coordinated actions for staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse.

Standard 115.366 Preservation of ability to protect residents from contact with abusers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There are no barriers preventing the Superintendent from removing alleged staff, volunteer, or contractor sexual abusers from contact with residents pending the outcome of the investigation and a determination of discipline.

The facility staff are represented by Communications Workers of America, AFL-CIO. There is nothing within the collective bargaining agreement that precludes the OCJDC administration from removing an employee from contact with youth while an incident is under investigation or terminating employment after a substantiated allegation against the employee for sexual abuse.

Standard 115.367 Agency protection against retaliation

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The OCJDC written policy related to protection against retaliation tasks the PREA Coordinator with monitoring youth who have reported sexual abuse or sexual harassment. The Superintendent is tasked with monitoring staff who have reported sexual abuse or sexual harassment. Should any other person who cooperates with a sexual misconduct investigation express fear of retaliation; appropriate protective measures will be taken. Retaliation monitoring will be discontinued should the allegation be unfounded. Measures include housing changes, removing contact of alleged staff/resident abusers and emotional support services for those who fear retaliation. There have been no instances retaliation for reporting. The auditor recommended that a logbook is kept of each time contact is made with a resident or staff to follow-up that there has been no retaliation.

Standard 115.368 Post-allegation protective custody

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard is not applicable. The facility does not use segregated housing of residents as a means to keep them safe from sexual misconduct. Interviews confirmed the prohibition of segregated housing for this purpose.

Standard 115.371 Criminal and administrative agency investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The auditor reviewed agency investigative files. The facility had one active on-going investigation that was being investigated by both the Department of Children & Families Institutional Abuse Investigation Unit and the Ocean County Prosecutor's Office. The incident was been properly investigated and documented as outlined by PREA standards. The facility cooperated with outside investigators and remained informed of the investigation progress. The final outcome was returned by investigators while under the corrective action period and the incident was determined to be Unfounded.

Administrative investigations include efforts to determine whether staff actions/failures contributed to the abuse documented through written reports which will include physical/testimonial evidence, credibility reasoning assessments and investigative facts and findings. The auditor recommended strengthening training to line staff regarding the processes during an investigation, and more importantly, the open culture of reviewing incidents afterward to change practices that can help to create a better, safer environment for both staff and youth. Line staff may some times feel that reviews are punitive or blaming when the process should be viewed as continuous improvement. At the time of the on-site portion of the audit the OCJDC Administrative investigators had not received specialized training in administrative investigations. All written reports are retained for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

CORRECTIVE ACTION: The auditor required staff designated as Administrative Investigators complete specialized training. The auditor recommended the NIC course in Investigations. On June 1, 2016 the facility staff provided training certificates for the staff who have completed the NIC course *PREA: Investigating Sexual Abuse in a Confinement Setting* to better able them to assist with administrative investigations.

Standard 115.372 Evidentiary standards for administrative investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The OCJDC uses no standard higher than a preponderance of evidence in making a determination of alleged sexual abuse/harassment. Through review of investigative files and interviews with the administrators and investigators it they use no standard higher than the preponderance of evidence in making final determinations of sexual abuse/harassment.

Standard 115.373 Reporting to residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

At the time of the on-site portion of the audit the OCJDC had no established method for documenting that residents were informed as to whether the allegation was substantiated, unsubstantiated or unfounded. The staff were not aware of the requirement to notify the resident nor were they able to identify a way in which to document this notice.

CORRECTIVE ACTION: The auditor recommended that the facility develop a form that can document notice to a resident of the outcome of a sexual abuse or sexual harassment investigation. On March 16, 2016 the OCJDC provided the auditor the form they developed and to document an investigative outcome to the resident.

Standard 115.376 Disciplinary sanctions for staff

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

All staff members who violate sexual abuse, sexual harassment and retaliation policies are subject to disciplinary sanctions. Interviews conducted with the PREA Coordinator and the Chief of Custody verified that there had been no substantiated allegations at the facility over the past reporting period. Interviews and a review of previous years incidents confirmed that this standard would be followed should disciplinary measures be required including a report to law enforcement and relevant licensing authorities should termination and/or resignation of staff occur.

Standard 115.377 Corrective actions for contractors and volunteers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Any contractor or volunteer who violate sexual abuse, sexual harassment and retaliation policies are subject to disciplinary sanctions including termination of service. There have been no contractors or volunteers who have been accused of sexual misconduct.

Standard 115.378 Disciplinary sanctions for residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

For incidents of youth-on-youth sexual abuse, sexual harassment or retaliation, administrative sanctions will be handed out following the formal disciplinary processes and applied commensurate with the level of infraction. For criminal allegations following a criminal finding of guilt for resident-on-resident sexual abuse disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed.

A youth's access to general programming or education is not conditional on receiving interventions designed to address/correct underlying reasons or motivations for abuse. Discipline of a resident for sexual contact with staff occurs only upon a finding that the staff member did not consent to such contact.

Standard 115.381 Medical and mental health screenings; history of sexual abuse.

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The staff were not conducting a specific PREA screening. However, the Social Services workers did interview youth within 72 hours of arrival. Youth who disclose previous sexual abuse are evaluated by their professional judgment and provided counseling as needed. They report any previously unreported sexual abuse to DCP&P. As a matter of course DCP&P may assign a Care Management Organization (CMO) worker to the youth who can then evaluate and provide professional counseling services and therapy. The facility verbally obtains informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting for residents over 18 years of age.

Once the screening tool has been implemented they will document their offer of a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening and document the offer and whether the resident desires to have follow-up with a medical or mental health practitioner. This will be documented in the Social Services Workers case notes.

CORRECTIVE ACTION: The auditor required verification that all youth in the facility had been screened. Also, the auditor required that if screening documents indicated prior sexual victimization or previously perpetrated sexual abuse the OCJDC staff document the offer of a follow-up meeting with a medical or mental health practitioner was made and whether the resident desired follow-up care. On April 29, 2016 the facility provided a sample of their form that will be used to document the offer for follow-up care. The auditor required a sample of a written informed consent form for residents over 18 years of age. On March 10, 2016 OCJDC staff provided their form "Authorization to Release Protected Health Information".

Standard 115.382 Access to emergency medical and mental health services

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility provides access to emergency medical and mental health services. In the event services after hours are not available by the facility medical and mental health staff, or where indicated in the professional judgment of the medical staff residents would be taken to the Community Medical Center in Toms River. These services have not been used during the audit review period.

Standard 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility will require that medical and mental health evaluations and treatment is offered at no cost to sexual abuse victims and abusers. The Supervising Social worker stated that in many instances services are accessed through the Department of Children and Families, Care Management Organizations (CMO's) that provide a range of treatment and support services to children. Once a Care Management worker is assigned, those services would follow a resident that is transferred or discharged. If a youth will be taken to the local, tests for sexually transmitted infections and pregnancy are offered will be offered there. They also access services in regard to sexually transmitted diseases and pregnancy through the Health Department located adjacent to the detention center.

Standard 115.386 Sexual abuse incident reviews

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility did not conduct formal sexual abuse incident reviews following each sexual abuse investigation specifically answering the questions posed within the standard. The auditor recommended a consistent date each month is set for the review of any incidents from the previous month. This review should include upper-level staff, supervisors, investigators, and medical and mental health staff.

Corrective Action: The auditor required that the OCJDC devise a means of documenting a formal review process and ensure a review is completed within 30 days after each incident, unless the incident is unfounded. On March 3, 2016 the facility provided their spreadsheet "Data Collection of Sexual Victimization". This form tracks all details of each incident, including the incident review.

Standard 115.387 Data collection

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility had not collect uniform data for all allegations of sexual abuse based on incident reports and investigation files.

CORRECTIVE ACTION: The auditor required the OCJDC staff provide the auditor a spreadsheet or some other documentation of their aggregate data for the previous calendar year. Also, the facility must provide 2013, 2014, and 2015 data. On March 1, 2016 the OCJDC staff provided aggregate data to the auditor. On March 3, 2016 the facility provided their spreadsheet "Data Collection of Sexual Victimization". This form tracks all details of each incident.

Standard 115.388 Data review for corrective action

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

At the time of the on-site portion of the audit the facility had not held an annual review of data or prepared an annual report. This review should be attended by all upper level managers and should report findings and corrective actions as well as the progress made through the previous year in addressing sexual abuse.

Corrective Action: The auditor required the facility prepare an annual report assessing the facility's progress in addressing sexual abuse and post this annual report on the agency's website. Senior level managers shall review all incidents for corrective action measures. On March 1, 2016 the OCJDC staff provided the auditor the OCJDC Annual Report. On March 21, 2016 the auditor verified that the Annual Report was posted publically on the OCJDC website.

Standard 115.389 Data storage, publication and destruction

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility had not posted data to their website. Data collected is retained via limited access and through a secure server for at least ten (10) years.

CORRECTIVE ACTION: The auditor required that OCJDC staff post aggregate data on the detention facility's website http://www.co.ocean.nj.us/OCJS/ . On March 21, 2016 the auditor verified that the aggregate data was posted on the website.

AUDITOR CERTIFICATION
I certify that:

- ☑ The contents of this report are accurate to the best of my knowledge.
- ☑ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☑ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Signature

June 27, 2016

Date